trust therefore only an additional cost of £10,000 per year would be required for a dedicated anaesthetist.

**0383: ARE THE NUMBER OF LYMPH NODES EXCISED DURING AXILLARY NODE CLEARANCE SURGERY AFFECTED BY NEOADJUVANT CHEMOTHERAPY?**

David Naumann, Martin Sintler, Sandwell and West Birmingham Hospitals NHS Trust, West Midlands, UK

**Introduction:** Neoadjuvant chemotherapy may change the macroscopic architecture of lymph nodes (LN) to such a degree that the number counted by a histologist following axillary node clearance (ANC) is lower than expected by the surgeon. We test the hypothesis that chemotherapy prior to ANC reduces the number of LN.

**Methods:** Retrospective study examining records for all patients undergoing ANC at a NHS Trust over a 17 month period. We compared the number of LN counted on histological examination between the patient groups who had received neoadjuvant chemotherapy and those who had not, with further subdivision into groups who had undergone sentinel node biopsy (SNB) prior to ANC and those who had not.

**Results:** There were 237 ANC operations including 98 ANC alone, 36 ANC following chemotherapy but no SNB, 61 ANC following SNB but no chemotherapy, and 42 following both SNB and chemotherapy, yielding 14.4 (±6.5), 13.0 (±5.8), 14.3 (±5.1), and 15.1 (±5.5) mean LN respectively (p = 0.398).

**Conclusion:** We find no statistically significant difference in the number of LN from excised axillary tissues between patients who received neo-adjuvant chemotherapy and those who had not. Lower than expected number of LN may not credibly be attributed to neo-adjuvant chemotherapy.

**0387: BLUE DYE DIRECTED AXILLARY NODE SAMPLING- VISITING THE ROLE**

Rachel French, Vijay Kurup. University Hospital North Tees, Stockton-on-Tees, UK

**Aim:** To evaluate whether combination of Sentinel Lymph Node Biopsy (SLNB) using patent blue dye and four node sampling as a reasonable alternative to SLNB (dual technique), in early breast cancer as guidelines recommend.

**Methods:** A retrospective study of SLNB using patent blue dye and four nodes sampling performed by a single surgeon from 2006–11. All 245patients treated by WLE were included. SLN were localised by injecting 2 ml patient blue dye in the subareolar with further Level 1 sampling done to achieve a minimum of 4 nodes, by palpation. Node positive axillae were treated by radiotherapy or clearance as per MDT decision.

**Results:** The detection rate was 97.95% (240/245 patients). 41 patients had axillary metastases- 38 cases SLN positive and 3 Negative. False negative rate 1.5%. Sensitivity 92.7% and negative predictive value 98.5%. 21/41 patients (51.2%) had only one node involved in their axilla. Axillary morbidity was minimal and recurrence nil at 5 years.

**Conclusion:** Injection technique and experience of surgeon can lead up to 98.5% SLN detection using blue dye alone with comparable false negativity. Combining with four node sampling reduces the impact of false negativity and avoids unnecessary axillary clearance in single node disease (51.2%).

**0432: TRIPLE NEGATIVE BREAST CANCER: BACKGROUND, TREATMENT AND FUTURE OPTIONS**

Rebecca Watts-Cherry, Eleri Davies, 1 Cardiff University, Cardiff, UK; 2 Llandough Hospital, Cardiff, UK

**Aims:** Identify a subgroup of patients who were diagnosed with triple-negative breast cancer (TNBC) in Cardiff and Vale (CAV) in 2006-2011, to enable an understanding of how TNBC patients present, what treatment is given and which patients had recurrences.

**Method:** This was a retrospective study. The pathology database gave a list of TNBC patients. Using this information, the Clinical Portal and CANNISC databases allowed the proforma to be completed, which was then analysed. All people diagnosed as having TNBC in CAV in 2006 - 2011 were included. No age or gender restriction was imposed.

**Results:** 101 patients were included in the study, of these 77 (76%) are alive up to 5 years after. 11 (11%) developed recurrences and 7 (7%) developed metastasis. Of these 86% had grade 3 tumours (study average (sa)=79%), 86% had invasive ductal carcinoma (sa= 87%) and the average size was 54mm (sa= 33mm). 67 (66%) patients received chemotherapy which was found to enhance survival (p=0.003).

**Conclusion:** TNBC disease is very responsive to chemotherapy agents, so must be given to all triple-negative patients as routine treatment irrespective to the histological result. The results obtained compare appropriately with the majority of studies already conducted.

**0438: DIFFERENCES IN PATIENT EXPERIENCE AND UNDERSTANDING OF CONSENT WHEN CARRIED OUT IN CLINIC AND ON THE DAY OF SURGERY**

Amy Lord, Shehryer Naqui, Ramesh Babu, Richard Sainsbury. St Mary’s Hospital, Isle of Wight, UK

**Aims:** To assess patients’ subjective perception of consent and recall of information when comparing those consented in clinic with those consented immediately before surgery.

**Methods:** Prospective study of patients undergoing breast and general surgical operations. Patients were randomised to consent in clinic or consent immediately before surgery. Patients completed a post-operative questionnaire assessing satisfaction and recall of complications using a tick-box list of 16 common complications, 6 of which were correct for each operation. An overall score of correct minus incorrect answers was calculated out of 6.

**Results:** 27 patients were included, 17 consented immediately pre-operatively, and 10 in clinic (mean - 13 days pre-op). The overall mean score for recollection of complications was 3 when consented on the day and 2.9 when consented in clinic. Subjective ratings of experience were not significantly different between the groups. Overall recall rates were better for general complications (96% bleeding, 100% infection and 74% anaesthetic risk) than specific risks (25% seroma in breast patients).

**Conclusions:** In our experience patients can be consented either in clinic or on the day of operation as there is no difference in their subjective perceptions or recall of information. However only small numbers have been assessed so far.

**0457: IS MAMMOGRAM AN ESSENTIAL INVESTIGATION FOR DETECTING BREAST CANCER IN PATIENTS YOUNGER THAN 40 YEARS?**

Annabelle Williams, Rachel Hung, Yazan Masannat, Anil Desai, Prakash Sinha. Princess Royal University Hospital, London, UK

**Aims:** Breast cancer is the commonest female cancer diagnosed in the UK. In November 2010, the 'Best Practice Diagnostic Guidelines for Patients Presenting with Breast Symptoms' were amended. This study aims to evaluate the safety of the proposed changes that state mammography is no longer an essential first line investigation for women under the age of 40, with breast symptoms.

**Methods:** A retrospective cohort study of 40 patients, from January 2007 to July 2011, with histologically confirmed breast cancer diagnosed when under the age of 40 was performed by comparing mammography and ultrasound results.

**Results:** All patients presented with a symptomatic lump and underwent ultrasound scanning, mammography and core biopsy. No patient with a normal ultrasound was found to have an abnormal mammogram. In all 40 patients ultrasound scanning showed 100% sensitivity in identifying the breast lesions with 95% identified as indeterminate, suspicious or malignant radiologically.

**Conclusions:** The new symptomatic breast guidelines are safe to implement, as ultrasound is an adequate first line investigation. If any suspicious ultrasound abnormality is detected then mammogram is essential for further assessment as this could demonstrate further pathological changes which may affect clinical management. This should lead to improved patient care and resource management.

**0471: BREAST PAIN UNDER THE AGE OF 50: IS MAMMOGRAPHY REALLY NECESSARY?**

R.E. Foulkes, R. Thomas, S. Ghosh. Nevill Hall Hospital, Abergavenny, UK

**Aim:** The aim of this study was to assess whether routine mammography in patients presenting with painful breasts, and no palpable mass is necessary in those under the age of 50 years.
Methods: All patients attending breast clinic between 1st January 2008 - 31st December 2010 with breast pain only, undergoing mammography, were assessed. Patients were then divided into the under 50 and over 50 age group for comparison.

Results: 315 patients were assessed, 168 (53%) were under 50 years old (mean 43). All had clinically normal breasts on examination. Six (3.5%) patients had indeterminate mammographic abnormalities in the under 50’s age group, versus eight (5%) in the over 50’s group. All had benign findings following further investigation. One (0.6%) patient in the under 50’s group had a malignant mammographic abnormality - this was on the asymptomatic side in a 48 year old. In those patients over 50 years, three (2%) had malignant abnormalities on mammography, of which two were confirmed malignancies.

Conclusions: Malignancy is rare in patients under the age of 50 presenting with pain only. In the setting of a normal clinical examination, routine mammography is not necessary, and may lead to further unnecessary investigations and anxiety.

0571: MAJOR BREAST AND AXILLARY SURGERY – FEASIBILITY OF A 23 HOUR PATHWAY
Rachel Clancy, Roger Watkins. Frenchay Hospital, Bristol, UK

Aims: Length of hospital stay for mastectomy patients has declined. Hospital Episode Statistics data for 2010-11 showed the average length of stay is still almost four days. Without compromising clinical care the aim of this study was to evaluate the feasibility and safety of a new pathway aimed at discharging patients within 24 hours of surgery.

Methods: From December 2008 suitable breast cancer patients requiring mastectomy and/or major axillary surgery were offered same day admission and discharge home within 24 hours.

Results: 126 patients (mean age 60; range 27-86) were included from 2008-2011. 99(79%) underwent mastectomy with either axillary node sampling (ANS) (10), sentinel lymph node biopsy (SNB)/99, axillary node clearance (ANC)/20 or no axillary procedure (10). 4 (3%) had bilateral mastectomy with either ANS/1, SNB/2 or no axillary procedure (1). 18% patients underwent ANC with either wide local excision (4), repeat excision (1) or no breast procedure (18). 97(77%) patients were discharged within 24 hours. 24(19%) were discharged on second day and 4(3%) required a three night stay. One patient developed ventilatory problems post-operatively requiring transfer to ITU. None of the 97 patients required unplanned readmission.

Conclusions: Major breast and axillary surgery can be safely performed with a minimal length of post-operative stay in suitable patients.

0589: ONE-STAGE DELAYED BREAST RECONSTRUCTION USING STRATITUDE AND PERMANENT IMPLANT
Victoria Bonello, Siva Gopalaswamy, Sheikh Ahmad. Royal Cornwall Hospital, Truro, Cornwall, UK

Aim: This case series aims to determine the degree of patient satisfaction and complication rates associated with a novel method of one-stage delayed breast reconstruction. Method: Six patients underwent reconstruction, one of which was bilateral, over an eight-month period. Stratitc® was used to create a subpectoral/allogenic graft pocket capacious enough to accommodate a permanent implant, hence eliminating the need for further intervention following the index procedure. The creation of a neo-inframammary fold was essential to produce a natural appearance.

0600: GYNECOMASTIA: IS IT COST-EFFECTIVE TO INVESTIGATE ALL PATIENTS IN A FINANCIALLY RESTRAINED NHS?
Habib Tafazal, Hiren Chauhan, Mehbboob Mirza. Sandwell General Hospital, Birmingham, UK

Aim: Gynecomastia is a common condition, with many men being referred to the already busy rapid access breast clinic. As surgery for gynecomastia is classed as non-essential, is it cost-effective to investigate all patients?

Method: Retrospective analysis of 97 patients referred from primary care. All patients were male, aged 17 to 89 years. The costs of the following investigations were calculated. Blood tests including LFTs, U&Es, TSH, FSH, LH, prolactin, testosterone, oestradiol, AFP, HCG and imaging in the form of mammography and ultrasound.

Results: The cost of a complete set of blood tests for each patient, including staffing and reagents, totals £35. Mammography and ultrasound cost £110 each. 87% of the patients were investigated with blood tests; the majority of which were normal. 43% had a mammogram, 52% had an ultrasound. Neither breast cancer nor endocrine pathology was detected in any cases. Total cost of the blood tests was £3000; mammography costs were over £4500.

Conclusions: Investigating all patients may not be cost effective but a selected combination of tests may be useful. We recommend that blood tests do not add value towards diagnosis and are an unnecessary additional cost to the already financially restrained NHS.

0649: A COMPLETE AUDIT CYCLE OF PREOPERATIVE SURGICAL SITE MARKING VERIFICATION CHECKLIST

Aims: Correct preoperative surgical site marking is a major patient safety issue. The aim of this audit was to examine the compliance with preoperative surgical site marking verification checklist (PMVC) used at this trust.

Methods: A prospective audit (101-patients) and a re-audit following staff education (125-patients) examined PMVC for correct written confirmation of: (a) side and procedure, (b) marking verification checks on ward (checks 1 and 2), and preoperatively in theatre (checks 3 and 4), (d) safety net signings if any of checks 1-4 were not completed (checks 5 and 6).

Results: All patients had correct side and operation description listed. Ward documentation for checks 1 and 2 were complete in 100% and 97% in initial-audit, and in 100% and 98% in re-audit period, respectively. In theatre documentation for checks 3 and 4 were complete in 70% and 48% in initial-audit, and in 80% and 74% in re-audit period. Further safety net checks 5 and 6 were not completed in either case (initial-audit–58%, re-audit–36%). No inadvertent side surgery error occurred in either cohort.

Conclusions: A significant improvement in practice was demonstrated following staff education and regular close audit is necessary to ensure compliance to PMVC which is pivotal in preventing error.

0664: IMPACT OF PROPHYLACTIC ANTIBIOTICS ON THE INCIDENCE OF POST-OPERATIVE WOUND INFECTION AND SUBSEQUENT DELAY IN ADJUVANT THERAPY FOR BREAST CANCER
Dilraj Bilku, Caroline Brammer. Royal Wolverhampton Hospital NHS Trust, Wolverhampton, West Midlands, UK

Introduction: Breast surgery is considered clean but studies have shown rates of infection to be 3% to 30%. Wound infection results in the delayed start of adjuvant breast cancer treatment. We therefore conducted an audit to analyse compliance with guidelines (SIGN guideline 84,104).

Methods: 68 patients undergoing radiotherapy following wide local excision for breast cancer across four units were analysed. Data was extracted from treatment sheets, operation notes and anaesthetic charts.

Results: Antibiotic prophylaxis was administered in 28 patients (41%) of which six (21%) developed wound infection. No antibiotics were given in 40 patients (59%) of which 20 (50%) developed wound infection. There was a delay in the initiation of radiotherapy in 31 patients. In two patients (7%) the delay was due to wound infection while in ten patients (32%) the delay was due to wound infection and adjuvant chemotherapy.